

Readiness to Change in PTSD Treatment 5

Written Video Transcript

Okay. So, first session—we have done this session, just one session—full review of the rationale and purpose. Just like I told you, we try to get them to use some of our jargon, like blindsided. The group's about preventing being blindsided. [00:00.20.00] Might have, we actually have patients saying middle column, is the language I might fall into because that's always been the might have on the forms we use. Talk about the spiral. Can we just go back for that one? [00:00.40.00] Okay. The key part of this group is to have patients look at the might have and decide if there are definitely or definitely not problems they need to work on. And that we cover this in the rationale and I try to emphasize that. Again the forms we're using now have that might have column split into the wondered [00:01.00.00] other people say. Those are the two types of might have. Form one is the form that patients carry through the entire group with them, they carry through with them. This is what they're working off. This is everything that the group is about is really right here. And it's that middle column. [00:01.20.00] Okay, this would be an example of how a patient might fill this out. It's different for different patients. Some patients, they have lots of definitely have and it's only a couple of might have. Alright? That's typically how the don't [00:01.40.00] have look, more health related kinds of things. Okay. What the goal is, is to have patients move things literally, using arrows, from the might have column to definitely have and definitely do not have. That's the goal. And again, you've got to bite your tongue sometime because even after all this careful work [00:02.00.00] and the different modules we use you see them moving that might have over to that right hand column, can't say anything. But I'm going to show you some data that makes me worry less about that. Anyway, I'm going to talk about the comparison to norms module that we've worked on. [00:02.20.00] First of all, let me say that the general strategy in group is we do a group example. So, we'll take a problem that might be a might have for somebody and then we generate group feedback. And then after we do the group we have people use the individual tool or method here for a particular might have that they have. [00:02.40.00] And they will do that on their own and then report back to the group. We try to involve as much group process stuff as possible. So, we try to integrate behavioral stuff with group process stuff with some of these motivational interviewing techniques. Comparison to the average guy, we ask people to [00:03.00.00] set up a continuum of problem severity from what the average guy is doing through what a moderate problem is to what an extreme problem is. This could be true for alcohol, anger, hypervigilance, weapons ownership. And usually when you set up a continuum like this you ask people to look at three things, the frequency of how often [00:03.20.00] somebody does something—all right, so we have trust problems or within relationship intimacy ones. I always ask the guys, well, how much do they think the average guy says I love you to his, his wife? All right, so real concrete kinds of things. What are the negative consequences to the [00:03.40.00] behavior at the average guy level versus more extreme problems and then the purpose. I'm going to talk a little



bit that. Let's use hypervigilance, which is a good group example. The guys understand this most clearly. So, we tend to use this as the group example that we get it, [00:04.00.00] we generate it from the patients. This turns out to be the easiest one and turns up the most. So, what's the average guy doing in terms of being on guard? Probably checks the locks before bed. He's out the cost of locks or lights if he puts up a security light. The purpose, you want to feel more secure, [00:04.20.00] feel a little better, feel a little more safe. Now somebody who's got a moderate problem with hypervigilance, they're not checking the locks once. They're checking the locks more than once. They may have a gun. Maybe the gun is not locked up. You know, a lot of our guys have guns under their pillows. You know Audie Murphy had a gun under his pillow for many, many years [00:04.40.00] after his World War II experiences. The neighbors might be a little nervous because they know this guy got guns. Now, of course some parts of the country this is not, you know, it's not normative. And it's very important because the guys will say, "Well, you know, this doesn't make sense to me," and they're right. It depends. If you live in some neighborhoods, [00:05.00.00] you know, you should have a gun. Right? We should give them a gun just to make they get to therapy by the next time. Okay? Some parts of the country—what's that scene in Miss Congeniality where she jumps on somebody in Texas, right, there in the pageant in Texas and they—because they say everybody's got a gun in Texas. I don't know if that's true. [00:05.20.00] But you want to be, you know, you want to be reasonable with the patient. You (always go), "Yeah, it depends." Because it does depend. I think when it doesn't depend is where you're into an extreme problem. Anyway, what's the purpose when someone's having a little bit of problem with hypervigilance? Now they're more worried about safety. [00:05.40.00] They're more worried about feeling safe. And of course an extreme problem is constant lock checking, seeing threats everywhere. And the purpose is important here. It becomes a feeling of life or death. And that's one way to distinguish whether you're closer to the average guy or further out. The purpose of all these modules [00:06.00.00] is to help you decide if the might have belong as definitely have or don't have. So that's what all these modules are geared towards. And I hope you see that this is, you know, you would take a might have and then apply this to it. Now, [00:06.20.00] the way we get around some of the—a lot of problems about what's average, first of all I stopped using the word normal after the first time we did this group. The second thing is if you get a large group of people, even our combat vets, most of the group, most of the group for a particular problem [00:06.40.00] will know what's average. They will know what's average. So what we do, it's a little hairy sometime, but we do a group feedback, "What's average?" We ask the patients and then what we do is to avoid fist fights we set up—we don't say there's one number, which of course is not true, but there's a range. So we get sort up upper and lower range that most of the [00:07.00.00] group agrees with. The most obvious example if you go into a group of veterans that we worked with, you say, "What's normative for alcohol?" Guys say you know, six beers a night, three beers a night. And then some of the patients will, you know, they'll say well you know, a couple of six packs or a six pack. [00:07.20.00] Because everybody they're hanging out with is doing that. Everyone they've hung out for 30 years is doing that. But of course they're the ones that are probably going to have it as a might have. So, it has turned out to be very powerful. Except for one thing, for all



these guys born in the early—I guess born in the ‘40s, raised in the ‘50s, then teenagers in the ‘60s, try to get [00:07.40.00] from the group any sort of normative estimate of pot use is impossible. So, I stopped asking about that as an example. It’s a group that’s a little more complicated for the guys. We’re going to rework this a little bit. We’re going to do some different things. But it’s very, but it’s very powerful if you spend some time on it. [00:08.00.00] A very powerful technique, pros and cons. We talked about that relating to ambivalence that a lot of people probably operating from pros and cons. And one of the important things about doing this with people for their might haves, applying pros and cons to might haves, it gets them to weigh out [00:08.20.00] things and see things they hadn’t seen. You don’t hit them with all the negatives they haven’t seen. But you hit them with some of that. But also you get all the guys to support each other around, well, maybe there’s some pros you’ve underestimated about why you keep doing it. And guys that’s very helpful. And then of course guys will say well maybe there’s some disadvantages you haven’t thought of. [00:08.40.00] And this has worked out, for a simple technique very powerful, very powerful. And this is just an example of what you see a lot, or might have, is being in control all the time, got to be in control. These are some of the benefits. Again we would do this as a group, [00:09.00.00] (we might) put this up and get feedback and then we’d have people do them individually and then put up individual ones. Okay, I’m just going to go through that. Roadblocks is another module we found to be very useful. This gets back to the things that would stop someone from admitting they have a problem, [00:09.20.00] particularly behaviors or beliefs. And we illicit feedback from the group on things that might stop someone from taking an honest look at themselves. What works great is we have this, you know, big group discussion and I’m listing, the group’s leader is listing all these things patients are saying. The patient’s saying shame, guilt. [00:09.40.00] And then what we do is we turn the tables on them a little bit. We say, "Okay all these things that can get in someone’s way, you list the things that you think apply to you." It’s a very quiet group after that. It’s a very somber group. And they do do it. The patients will do it. The patients will do it. Some of the roadblocks, [00:10.00.00] internal stereotypes I mentioned before and I have discussions with patients about that. And it makes a lot of sense. We use a lot of media. And I think all of us are influenced by media when we’re young in terms of views of what’s an alcoholic, drug abuse, psychiatric patients. Vietnam vets, how they’ve been portrayed. Fears, fears of failure. You know, why would I want to take a look at new things [00:10.20.00] to work on, it’s just more things to fail at. A lot of different fears. And I think success avoidance stuff too. Distortions, you know, if I have this problem it means I’m a terrible person who’s doomed to die. A lot of things we focus on, issues around shame, guilt, the things that stop people [00:10.40.00] from looking at themselves. Okay. Now, we’ve tried a model how to handle oppositional difficult clients in the group. And we’ve had to deal with many of them. Right? There are some group coleaders here. Gil Ramirez has helped me many times and dealt successfully [00:11.00.00] with difficult clients because they’re not any nicer in our groups than they are in the other group. Right, even though we’re doing this big, you know, nonconfrontational thing. It’s not like patients don’t stand up and say, "I think this is a lot of bologna." They say it to me just as much as they say it to anybody else. But I think what you have to start to do is to be—and there’s got, again, to be an atmosphere



[00:11.20.00] both for the therapist and the clients to say, "You know what, I think what you're saying is important. I bet other patients are thinking the same thing. And I may not have made it clear what the rationale is." And I think it is important to make every response short of outright insulting your family, right—and even then you say, you know, I know you've got—Fred (Gusman's) [00:11.40.00] phrase—I know you've got an important message here but it's really hard to hear when you phrase it like that. And you can't address us like that but let's talk about your important message. And that works, I don't know, what 80% of the time? So, every response is understandable. We do a lot of emphasis on what this group is about, [00:12.00.00] especially avoid being blindsided. The patients buy that. The patients really buy that. And so a lot of questions about the rationale. We just have to remind them of what we talked about. Talked to you about confrontation. Give them these speeches about, you know—our patients don't like being here. [00:12.20.00] Right? And they might want money. They might want help. they might want both. But they really don't like being in treatment. And I think no patient does. I would worry about any patient that wants to be in therapy. Okay, I haven't had any patients like that. I wouldn't know what to do with a patient who really, genuinely came in and said, "I really need your help and, you know, I've heard good things [00:12.40.00] about you and I really want to get better." I don't believe patients who say those things. Because from what I'm working with, the model I have, the things that are getting us in trouble are the things that we don't really want to look at. Because if we wanted to look at them you wouldn't be in that office to begin with. So, I tell patients, "You're going to be here. You're going to work really hard. [00:13.00.00] Don't lose all that hard work just because you've got a problem you don't want to look at just because somebody you don't like pointed it out to you." And that seems to have an effect on them. They seem to respond to that, not that I thought that they would. We have done a preliminary evaluation. This is an uncontrolled program evaluation of the effectiveness [00:13.20.00] of the PTSD motivation enhancement group. Two hundred forty three patients, again about 75% of the patients after each group. After each session we collected data on problems that they said they might have and also problems that they changed to definitely have [00:13.40.00] and change to definitely don't have. So, the data I'm going to talk to you about is only about problems that patients initially identified as might have. Okay? And then we measured and assessed did they change their minds. Did they move it out of the middle column? Okay. [00:14.00.00] I know this is probably hard to see and that's my fault, not the production team's. They tried to get me to make bigger slides. Now these are patients, let's take anger. Initially of all the patients, and it's about 50%, remember that, who said anger is a might have, we then looked at how many of them changed it to definitely have, [00:14.20.00] how many stayed the same, how many just moved it to definitely don't have. Now in particular the analysis I did was a (Chi Square) because if this model is really applicable here what you want to see is more guys changing might have to definitely have and don't have. Right? Because we're assuming there's an underlying problem. [00:14.40.00] So, the (Chi Square), the significant if there's an asterisk next to the problem, was comparing of the people who moved items—so, it's not including the middle group—of the people who moved items, was there a greater percent that moved them to definitely have. And yes, that's true for anger, isolation, trust, [00:15.00.00] emotional masking. Not hypervigilance, I think this



is going to be a hard nut to crack especially for the combat veterans. About half of them didn't even change. About a quarter of them felt, no. Anyway, and then less so, [00:15.20.00] no significant differences there, a lot of—70% of the patients did not change their minds there. Okay? But at least we got some results on anger, which I'm most concerned about. Isolation, also. And more patients changed their might have to definitely have for guilt, anxiety [00:15.40.00] and smoking. It's not like we addressed this. And I think this is important. We may have bumped people up a stage, right, whether they knew it or not, whether we knew it or not. Now they may slip back down but there's an opportunity here to kind of get people while they're bumped up, even though it's something that, you know, what I'm calling PTSD related problem. All right? [00:16.00.00] Relationship and intimacy. Not alcohol, not drug abuse. Now, but in opposite direction for being crazy, losing control. This is more of a testament to the program I think, than the PTSD motivation group when we ran it Menlo was that there was a significant difference. A lot of patients said that they're afraid [00:16.20.00] that they're crazy. A lot of them really don't understand PTSD. They try to say it on the intake and all. They really don't understand. A lot of our patients are terrified that they're crazy. They are crazy, I tell them a lot of times. They are crazy. But they're not crazy. And a lot of them come to believe they're not crazy. And that shows up in the statistics here and =

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